

## 1432 – STATE CHILD FATALITY REVIEW PROTOCOL

### CHANGE # 01-2007

January 2007

#### I. HISTORY AND PURPOSE OF STATE CHILD FATALITY REVIEW TEAM

In the Spring of 1991, three initiatives by the State established a statewide child fatality review system. These initiatives were the result of the growing awareness that child deaths in the State were both under-recognized and under-reported.

These initiatives were: (1) the request by the N.C. Legislature, the Department of Human Resources and several other private agencies that the American Bar Association's Center on Children and the Law assist the state in establishing a statewide child fatality review committee, (2) the publication of The North Carolina Child Advocacy Institute's "Deaths from Child Abuse and Neglect in North Carolina: Closing the Loopholes", and (3) Governor James G. Martin's issuance of Executive Order Number 142: Child Protective Services.

Governor Martin's Executive Order 142 directed the Division of Social Services (hereafter, the Division) to strengthen its supervision of county-administered child protective services programs. It called for Division review of child fatalities resulting from abuse and neglect and quarterly reports to the public on these deaths. The North Carolina General Assembly also responded to the growing concern over child deaths. It funded two consultant positions in the Division dedicated to reviewing child deaths when Child Protective Services (hereafter, CPS) has had prior contact with the child's family.

In 1997, the North Carolina General Assembly passed legislation that established a State Child Fatality Review Team. [N.C.G.S. §143B-150.20](#) states that this team is to: "conduct in-depth reviews of any child fatalities which have occurred involving children and families involved with local departments of social services child protective services in the 12 months preceding the fatality. Steps in this in-depth review shall include interviews with any individuals determined to have pertinent information as well as examination of any written materials containing pertinent information." The statute continues: "The purpose of these reviews shall be to implement a team approach to identifying factors which may have contributed to conditions leading to the fatality and to develop recommendations for improving coordination between local and State entities which might have avoided the threat of injury or fatality and to identify appropriate remedies. The Division of Social Services shall make public the findings and recommendations developed for each fatality reviewed relating to improving coordination between local and State entities." Furthermore: "The State Child Fatality Review Team shall include representatives of the local Departments of Social Services and the Division of Social Services, a member of the local Community Child Protection Team, a member of the Local Child Fatality Prevention Team, a representative from local law enforcement, a prevention specialist, and a medical professional." On July 4, 2003 this statute was amended to include provisions for accessing information while completing a State Child Fatality Review. This amendment provided the State Child

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Fatality Review Team the right to request a court order compelling disclosure when difficulties obtaining information are encountered.

A Child Fatality Review Team is convened by the Division to conduct a fatality review whenever there is a suspicion abuse or neglect has contributed to a child's death **and** a county **Department of Social Services (hereafter, DSS)** has had contact through its child welfare programs with the child or family within the 12 months preceding the child's death. The purpose of the review is to enable the Division, the county DSS, state and local agencies, and the local community to identify important issues related to child protection and to take appropriate action to improve our collective efforts to prevent child fatalities. The review process is a collaborative, multi-disciplinary effort that involves representatives of the Review Team as outlined in statute. The Review Team issues a formal, public report designed to stimulate system improvements. Whenever a person is criminally charged in the fatality, the report is reviewed by the local District Attorney to ensure that its content does not interfere with any criminal investigation or prosecution.

It is important to recognize that a child fatality review report is intended to provide information that can be put to constructive use in preventing future fatalities. These reports are made public **with the expectation** that community agencies, groups, and individuals can take positive action in the wake of tragic circumstances. **It is not the purpose of these reports to determine whether a person, group, or agency could have prevented a fatality.**

It is also important to recognize that while the **DSS** in each county is charged with conducting **CPS** assessments of reports of suspected child abuse and neglect, the DSS is not alone in its responsibility to protect children or in prevention efforts. Each DSS relies on the broader community to provide information and to conduct related **CPS assessments** and examinations that help DSS and the court system to make important decisions concerning the safety of children. Consequently, the review process places particular emphasis on issues of interagency collaboration, communication and decision-making.

## II. REPORTS OF CHILD FATALITIES TO THE DIVISION AND DECISION TO CONDUCT A REVIEW

According to [N.C.G.S. §7B-301](#), "any person or institution who has cause to suspect that a juvenile ... has died as a result of maltreatment shall report the case ... to the director of the department of social services in the county where the juvenile resides or is found." In turn, [N.C.G.S. §7B-311](#), requires that directors of county DSS report to the Department of Health and Human Services, Division of Social Services, all child fatalities that are a result of alleged maltreatment. **This report is made using the State Child Fatality Intake Form (Attachment A) which should be completed by the county DSS. This report is** used to determine whether the circumstances in the death meet the criteria for a Child Fatality Review. The report shall be made **to the Division** within 5 **business** days of the agency's knowledge of a fatality suspected to be as a result of maltreatment. The report shall be made **in writing by fax** to:

North Carolina Division of Social Services  
Family Services Manual  
Volume I: Children's Services  
Chapter VIII: Child Protective Services

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North Carolina Division of Social Services  
Family Support and Child Welfare Section  
Local Support Operations Team  
325 North Salisbury Street  
2439 Mail Services Center  
Raleigh, NC 27699-2439  
919-733-9467 / 919-733-3823 fax

Division staff may directly contact the medical, law enforcement, or human service professionals for additional information. The final decision to conduct the review will be made by the Division with input from the county DSS and other appropriate professionals. The decision to conduct a fatality review will be communicated to the county DSS after the Division obtains all pertinent information needed to make the final decision. The assigned Children's Program Representative (**hereafter, CPR**) will be contacted at the time that decision is made to conduct a review.

At the time the decision for a review is communicated to the county DSS, the Child Fatality Reviewer will ask the county DSS contact person to identify the Community Child Protection Team (**hereafter, CCPT**) chairperson. The Child Fatality Reviewer will then contact the chairperson of the CCPT to request a meeting of the CCPT **for the purpose of presenting** information about the fatality review process. If the CCPT does not have a regular meeting scheduled within 30 days of this contact, the CCPT will be asked to convene a special meeting within 30 days for the Child Fatality Reviewer to make this presentation. Every effort should be made to ensure full participation of the membership of the CCPT for this meeting. **For more detailed information on the CCPT process please refer to:** [Family Services Manual Volume I; Chapter VIII; Section 1434 – Community Child Protection Team](#).

### III. PREPARING FOR THE REVIEW

#### A. Presentation

The document, "Dimensions of an Intensive State Child Fatality Review" ([Attachment B](#)) provides an outline of the steps to be completed during the course of the fatality review. This is a general guideline and will be used flexibly as each fatality situation is unique.

The Division's Child Fatality Reviewer will meet with the membership of the local CCPT to explain the fact that a review must be conducted, the purpose of the review, the composition of the review team mandated by law. During this presentation, the Child Fatality Reviewer will note the legal mandates of the CCPT in conducting the State Child Fatality Review process, **along with the similarities and differences with the legal mandates for the State Child Fatality Review Team**.

**B. Selecting State Child Fatality Review Team Members**

The following guidelines shall be used in selecting Review Team Members:

1. A local law enforcement **representative** who, if possible, has not had direct contact with the case in question to be selected by the county CCPT
2. A medical professional who, if possible, has not had direct contact with the case in question **and** who should have particular expertise in the area of child abuse and neglect
3. A prevention specialist from an agency that provides prevention services to families and children who, if possible, has not had direct contact with the case in question who has knowledge of child abuse and neglect issues
4. A member of the local CCPT to be selected by the county CCPT (this person should have knowledge of children's services issues and DSS procedures)
5. A member of the local Child Fatality Prevention Team (CFPT) to be selected by the county CFPT (this person should have knowledge of children's services issues and DSS procedures)
6. A member of the local DSS staff **who, if possible, has not had direct contact with the case in question** to be selected by the county DSS

The county DSS or the local CCPT representative will be responsible for the collection and dissemination of team membership names, addresses, phone numbers, email addresses, and fax numbers.

**C. The DSS Case Record**

1. The county DSS must send a copy of the DSS case record to:

The **North Carolina** Division of Social Services  
Family Support and Child Welfare Services Section  
**Local Support Operations Team**  
325 **North** Salisbury Street  
2439 Mail Service Center  
Raleigh, NC, 27699-2439

A copy of all case documents will be made and provided to State Child Fatality Review Team members within adequate time for members to read and review prior to the on-site review.

2. The DSS case record should contain all child welfare information concerning the family or child, as well as Medicaid, **Work First** and Food Stamps eligibility and receipt. For example, if the child was in foster care, the agency will need to send a copy of the child's record along with any record of **CPS** provided to the child and family, as well as the foster parent record. If the county DSS has made a CPS report to another county DSS involved in the case, the information received from the other county DSS should also be sent. Any CPS reports that were not accepted for CPS assessment should also be included, **if available from the county DSS**.

**D. Other Agency Case Records**

In order to fully carryout the purpose of the review as specified in [N.C.G.S. §143B-150.20\(b\)](#), it will be necessary to **request** written material from other agencies that have had direct contact with the case. This legislation provides the authority to obtain these records per paragraph (d). The State Child Fatality Review Team members will discuss which records are needed and will decide together who will take responsibility for obtaining the written materials from these agencies. Individual team members may decide to take on this responsibility based on their professional connections for obtaining the records and for making copies for dissemination to the team. The Division's Child Fatality Reviewer will assist in the event that there are problems obtaining any of the needed information **as well as** with copying and dissemination if needed. The distribution of agency records must be completed with sufficient time to allow for members to read and review the materials prior to the on-site review meeting.

**E. Logistics**

1. The Child Fatality Reviewer and the designated State Child Fatality Review Team members will discuss the proposed length of time the review will require and determine a mutually convenient time to hold the review. Review Team Members will be informed that they must commit to participate for the number of days scheduled for the review. If an appointed person cannot make such a commitment, another person will be identified who can make this commitment.
2. The review can be held at the county DSS or at another location identified by the State Child Fatality Review Team members or the **chairperson** of the CCPT. In either case, the room chosen should be able to accommodate up to ten people. It will be helpful if a telephone with speakerphone capability can be located in the room. In the event that this is not possible, the host agency will be asked to identify a telephone nearby with this capability.

3. The Division's Fatality Reviewer must be notified in the event that the State Child Fatality Review Team's composition changes. No one may participate as a review team member without the prior knowledge and consent of the Division's Fatality Reviewer.
4. After receipt of the case records, each team member will provide to the Division's Child Fatality Reviewer a list of persons he / she wishes the team to interview. The Division's Child Fatality Reviewer will then forward this information to the county DSS contact person so that interviews can be scheduled. In every case, the DSS social workers for the child and family and their supervisors will be interviewed by the team. Generally, it is helpful to schedule interviews approximately one hour apart. However, the prospective interviewees should be informed that these time frames may have to change depending on circumstances. The State Child Fatality Review Team may designate someone other than the DSS contact person to arrange the interviews.
5. As the county DSS contact person (or any other person designated to arrange the interviews) talks with prospective interviewees, it **is** important that the Division's Fatality Reviewer **is informed** of any problems in interview scheduling. For example, if a physician says that he / she will not be available for the interview or if someone from another agency states that he / she does not believe **they are** required to be present for the interview, the Division's Child Fatality Reviewer should be informed immediately. In many cases, clarification of the purpose and role of the State Child Fatality Review Team and its authority to examine records and interview individuals will be enough to allay any concerns **the** individuals may have. **The** Division's Child Fatality Reviewer must be informed early so that such clarification can take place prior to the review.
6. The Division's Child Fatality Reviewer will send the State Child Fatality Review members a copy of the "Dimensions of an Intensive Fatality Review." This document outlines information regarding what the county DSS, local Review Team members, and the Division's Child Fatality Reviewer are expected to do as a part of the review process.

#### IV. CONDUCTING THE ON-SITE REVIEW

##### A. Entrance Conference

**These activities may be completed at a meeting prior to the actual on-site review meeting:**

1. Content - The entrance conference is designed to acquaint participants with the purpose and focus of child fatality reviews and to answer any questions about the review process. Information will be provided

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regarding the fatality review process and time frames for completion of the review and report.

2. Participants - Entrance conferences are open meetings. Consequently, attendance by media representatives and/or other interested community persons is permitted. Child Fatality Reviews are community focused. As a result, any agency and its staff that had contact with the child or family may attend. Persons named as interviewees may also attend the entrance conference, if they wish.

**B. Interviewing Process**

Face-to-face and telephone interviews with persons significant to the case are a major part of the Child Fatality Review. These interviews provide social workers, supervisors, and community agency staff with the opportunity to elaborate on their written documentation. Written documentation can address the essentials of the work with the family, but face-to-face interviews can detail the scope of the work. Interviews are conducted in a sensitive manner while also ensuring that relevant information is obtained. Generally, only those persons who have provided a service to the child or family while the family was known to DSS will be interviewed. There will be times, however, that private individuals may wish to approach the State Child Fatality Review Team with information he / she believes may be important. At the time of the review, case discussions may produce the names of other persons the State Child Fatality Review Team members want to interview. The CPR assigned to the DSS may be interviewed as well.

**C. Team Discussion of Preliminary Findings**

After the fact-finding portion of the review, the State Child Fatality Review Team members will meet to discuss preliminary findings. Generally, this meeting will last from one-and-a-half to two hours. A draft of the report will be reviewed at this time. This will provide stakeholders an opportunity to seek specific clarification on the findings and recommendations

**D. Exit Conference**

**This conference will occur after the Division has finalized the report.** Like the Entrance Conference, the Exit Conference is an open forum. It is designed to acquaint the agencies involved in the fatality review with the final report of the State Child Fatality Review. It is a time for clarification and answers to questions that may have arisen regarding the review process. Consequently, media representatives or other interested persons may attend.

## V. THE CHILD FATALITY REVIEW REPORT

### A. Process

#### 1. Content

Each State Child Fatality Review will culminate in the issuance of a "State Child Fatality Review: **Findings and Recommendations draft** report" ([Attachment C](#)) that, upon demand, can be released to the public once finalized. This report will address issues relating to agency collaboration, communication and decision-making. The report will also address specific issues within agencies that the review team identifies as having direct bearing on the prevention of child fatalities. The report will contain recommendations for agencies when there are issues directly related to the prevention of future child fatalities. The report will also contain recommendations for coordination between state and local entities that might have avoided the threat of injury or fatality and will identify appropriate remedies. It is strongly recommended that the report outline initial plans for action that can be initiated by the local community and its agencies. The Division's review will include guidance from legal counsel to ensure that the report does not disclose case specific information required to remain confidential or otherwise violate the law.

Release of Information in the **State Child Fatality Review** Report

The following categories of case specific information can be included in the final report:

- a. the name, gender, date of birth and date of death of the deceased child
- b. the fact that an investigation was conducted by the county DSS
- c. the fact that the State Child Fatality Review Team conducted a review
- d. the result of that review to the extent that it does **not** disclose any case specific information

#### 2. Review Draft of the Report

After receipt of the initial draft report State Child Fatality Review Team members will participate in a conference call to provide feedback to the Division Child Fatality Reviewer. This conference call will be scheduled prior to the close of the review. The State Child Fatality Review Team members may choose to have a face-to-face meeting, rather than a conference call. The State Child Fatality Review Team members will need to agree on the content of the report. Any concerns that the State Child Fatality Review Team members have will be addressed before the draft report becomes final.

3. Review by Local District Attorney  
Whenever anyone has been criminally charged in a child fatality, the Child Fatality Reviewer will send a copy of the draft report to the local District Attorney for review. The purpose of such a review is to ensure that the report does not compromise any criminal investigation, prosecution or interfere with a defendant's right to a fair trial.

**B. Issuance of the Final Report**

1. The Division's Child Fatality Reviewer will receive Division Management's feedback and incorporate any recommended changes.
2. The Division's Child Fatality Reviewer will send the report to the local District Attorney for approval. If the District Attorney recommends changes to the draft report in accordance with [N.C.G.S. §7B-2902\(d\)](#), the Division Child Fatality Reviewer will make those changes, and communicate the changes, if any, to all **State Child Fatality Review Team members**.
3. After the report has been finalized, copies will be sent to the **State Child Fatality Review Team** members and the directors of all agencies named in the report prior to releasing the report to any outside individuals/agencies.
4. After the report has been finalized **by the Division** and sent to the **directors** of all agencies named in the report, copies will be mailed to the following persons:
  - Chair**person** of the local Community Child Protection Team
  - Chair**person** of the local Child Fatality Prevention Team
  - Chair**person** of the local Social Services Board
  - The Director of the Division of Social Services
  - The Deputy Director of the Division of Social Services
  - The Program Administrator for the Family Support and Child Welfare Services Section
  - Counsel for the Division of Social Services
  - All **Family Support and Child Welfare** Team Leaders
  - The assigned Children's Program Representative
  - The Director of Prevent Child Abuse North Carolina
  - The Chief Medical Examiner
  - The Medical Director of the State Fatality Prevention Team
  - All members of the State Child Fatality Prevention Team
5. Dissemination of the State Child Fatality Review Report seldom takes place via a press conference. However, there are some cases in which the Division and county DSS determine that it is in the community's best

interest to release the report in this manner. This decision is made on a case by case basis.

**VI. PRESENTATION AND COMMUNITY RESPONSE TO THE STATE CHILD FATALITY REPORT**

**A. Local CCPT**

Following the on-site review, the State Child Fatality Review Team members will present the findings and recommendations to members of the local CCPT and agencies identified in the report. The purpose of this presentation is to clarify any issues contained in the report. The State Child Fatality Review Team will designate one of its members to make this presentation formally. However, it is strongly recommended that all members of the State Child Fatality Review Team be present for this presentation.

**B. Follow Up**

At approximately six months following the issuance of the State Child Fatality Review Report, a letter will be sent from the Division to the Chair of the local CCPT asking for feedback on specific actions the local community has taken in the aftermath of the fatality review. The response should include feedback from the community on the report's potential benefit to the community in helping to prevent future fatalities. This feedback will help the Division compile information on steps communities have taken to prevent future fatalities. This information will be used to develop the annual report to the General Assembly and will be disseminated to all local CCPT and to any state-level agencies that may need to address policy or practice issues.

[Attachment A: State Child Fatality Intake Form](#)

[Attachment B: Dimensions of an Intensive Fatality Review](#)

[Attachment C: Review Findings and Recommendations](#)

STATE CHILD FATALITY INTAKE FORM

Fax Completed Forms to Local Support Operations  
(919) 733-3823 fax

Date Prepared: \_\_\_\_\_ Prepared By: \_\_\_\_\_

County: \_\_\_\_\_ Assigned County CPR: \_\_\_\_\_

CPS Contact Person: \_\_\_\_\_ Director/Program Mgr.: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name of Deceased Child(ren): \_\_\_\_\_

Race \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Death \_\_\_\_\_

Surviving Children in the Home:

Name	Date of Birth	Race	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent / Caretaker:

Name	Address	Age	Race	Gender
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other Adults Involved:

Name	Address	Age	Race	Gender
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Status of Family's Case at Time of Child(ren)'s Death:

☐ Open CPS Assessment(s)      ☐ Open CPS In-Home Services      ☐ Closed CPS Case(s)  
☐ DSS Custody      ☐ Prior Screened Out Report(s)      ☐ No Prior CPS History  
☐ Family Preservation Services      ☐ Other (Specify : \_\_\_\_\_)

Prior Child Welfare Services (including screened out reports and all report dates and results):  
\_\_\_\_\_

STATE CHILD FATALITY INTAKE FORM

Known Circumstances of the Fatality (including a brief description of the circumstances surrounding this fatality including any physical injuries):

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Suspected Cause of Death \_\_\_\_\_

Autopsy Conducted: ☐ Yes ☐ No

Autopsy Results \_\_\_\_\_

Actions Taken by DSS in Regard to the Fatality and Future Actions Anticipated:

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List Other Professionals Involved with Fatality:  
Name Agency

Telephone

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List Anyone (other than above) Who Expressed Concern About Fatality:

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Pending Criminal Charges: \_\_\_\_\_



## **Dimensions of an Intensive Fatality Review**

- I. In addition to DSS, determine which agencies' records need to be requested.
  - A. Those agencies having significant knowledge of child, family and the situation leading up to the fatality and the assessment of fatality.
  - B. Ensuring the nine life domains have been addressed (safe place to live, family, social life / supports, educational life, physical health, emotional and psychological health, legal issues, safety and crisis issues, and cultural / ethnic issues).
- II. Determine those who will be interviewed.
  - A. Those individuals having significant knowledge of child, family and the situation leading up to fatality and the investigation of fatality.
  - B. Any DSS worker involved with the case and their supervisor, any law enforcement officer and their supervisor, and any other agencies' staff involved with the child and family.
  - C. Offer up to 10 minutes for any additional persons who wish to be heard but the team has not requested to interview. A maximum agreed upon allotted amount of time should be set before informing interested parties about review. If the time allotted is not sufficient, information can be submitted in written form to an identified person within a specified time frame.  
Telephone conference calls can be utilized as well.
  - D. No interviewees may remain with the State Child Fatality Team before the interview.
- III. Inform all those involved with the process, whether directly or indirectly, about the process (how, why, and what).
  - A. Identify those not scheduled to interview who wish to have input into the review fact finding and schedule time for them to speak.
  - B. This may be accomplished through an Entrance Conference format.
- IV. Put together a time frame of events, persons involved, and pertinent information.
- V. Overlay the nine life domains.
- VI. Note issues and questions as the time line is done and life domains are overlaid.

- VII. Conduct Interviews which cover the following:
  - A. Length of involvement with the child, family and/or situation.
  - B. Identify services offered, including the assessment and plan for the child and/or family.
  - C. Identify any barriers to services or meeting plan goals.
  - D. Clarification of issues raised by time line and life domains.
- VIII. Formulate findings of fact and recommendations.
- IX. Develop a plan of action and plan for follow-up
- X. Decide how to inform persons and agencies involved of initial findings and obtain their feedback on recommendations before writing the final report. This may be accomplished through an Exit Conference format.
- XI. If there are criminal charges pending, the report must be reviewed by the District Attorney prior to being publicly released.
- XII. Send a preliminary copy of the final, written report to any agency named in the report.
- XIII. Present the final, written report that includes findings, recommendations, and plan to the CCPT and interested public.
- XIV. The full CCPT will be offered the opportunity to file a written response to the Division regarding the Team's report. This response will be attached to the fatality review report and will be provided to anyone requesting a copy of the report.
- XV. Specific feedback regarding the actions taken by the local community will be requested from the CCPT approximately six months after the review took place.

# STATE CHILD FATALITY REVIEW FINDINGS AND RECOMMENDATIONS COUNTY , 200

Prepared by:

, Division of Social Services

State Child Fatality Review  
Findings and Recommendations  
County  
, 200

A State Child Fatality Review Team composed of County Community Child Protection / Child Fatality Prevention Team members and Division staff met on to review the death of . Since this family had been involved with the County Department of Social Services within the twelve months preceding death, an in-depth review was required pursuant to [N.C.G.S. §143B-150.20](#). According to paragraph (b) of the statute, "The purpose of these reviews shall be to implement a team approach to identify factors which may have contributed to conditions leading to the fatality and to develop recommendations for improving coordination between local and state entities which might have avoided the threat of injury or fatality and to identify appropriate remedies."

Toward this end, a State Child Fatality Review Team consisting of representatives as required by state law was convened on . Team members, their agency titles and roles were as follows:

Name	Agency Title	Role on Team

The Team reviewed pertinent records including police investigative data, medical examiner, and social service records. The Team also interviewed relevant personnel who provided professional, insightful information. The timeline was completed and the nine life domains (safe place to live, family, emotional / psychological, vocational / educational, physical health, legal, safety and crisis, social supports, and cultural / ethnic) were discussed. A summary of the report findings will be given to the full Community Child Protection Team and the Community Child Fatality Prevention Team in the near future.

\_\_\_\_\_ was born on \_\_\_\_\_ and died on \_\_\_\_\_, at the age of \_\_\_\_\_. According to the North Carolina Medical Examiner’s report, the cause of death was \_\_\_\_\_. The manner of death was \_\_\_\_\_. No criminal charges have been filed in this matter. Accordingly, the amount of information that may be released is limited.

**Findings and Recommendations**

During the Team’s review of the circumstances surrounding \_\_\_\_\_ death, several facts, themes and conclusions emerged.

**Findings:**

- \_\_\_\_\_.

**Recommendations:**

- \_\_\_\_\_.

While the Review Team developed its recommendations to better protect children in the future, it cannot be known what impact, if any, these recommendations could have had on the reviewed case if they had been in place at the time of the fatality.

In conclusion, the \_\_\_\_\_ Community Child Protection / Child Fatality Prevention Team would like to thank the agencies that provided information and personnel to conduct this review. It is our hope that changes in policies and practice resulting from this report will improve future service provision.